Subjective Illness Theories vs. Doctor Centred Conversation Techniques in Doctor-Patient Interaction

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Introduction: In contemporary medicine doctor – patient interaction is being pushed into the background by instrumental diagnostics and medication. Doctor-patient talks tend to get reduced to less than five-minute-long task allocation sessions focusing on lab findings and instructions on the drugs prescribed. The present study is intended to analyse verbal exchange between family doctors and their patients suffering from chronic diseases and thus trying to find answers to the question how the interactional structure of doctor-patient talk makes it possible or impairs the interactive elaboration of patients' lay illness theories and how these subjective lay illness theories influence the structure of the exchange.

Material and method: The study corpus includes an audio-taped conversation between family doctor and patient with hypertension. The transcription of the recording was carried out using transcribing computer software. The method of Conversation Analysis was used with special regard to turns, turn taking, the defence of the speaker's role and simultaneous speech.

Results: The analysis of these interactive structural devices clearly demonstrates the superior role of the representative of the institution in the whole interaction.

Conclusions: In this communicative inequality subjective utterances become unimportant, which carries the risk that they will not get repeated later on in the conversation with the doctor. No effective therapeutic cooperation is possible without the awareness of subjective illness theories.

Keywords: institutional interaction structure, doctor-patient consultation, subjective illness theories, communicative inequality

Introduction

In the present study analysing talk between family doctor and their patient with hypertension the physicians' dominance originating from differences in knowledge and the degree of involvement could be felt constantly [1]. Its manifestation, however, was not always clear at the structural level of the interactions. At the interpersonal level, thanks to the more than ten-year-long doctor-patient relationship, on several occasions confidential communication characteristic of equal individuals exchange could be observed instead of the professional's dominance over the layman. The six units of the doctor-patient encounter [2] constituting the macrostructure of the exchanges got reduced to four including presenting complaints, discussion of medication, measurement of the blood pressure and evaluation. In the development of the reduced structure, in addition to the specific character of the communicative purposes, the long-lasting doctor-patient relationship could also play a part. Consultation of patients with hypertension thus can be regarded as a specific form of doctor-patient consultation, a type of institutional encounters. It offers an outstanding occasion for the manifestation of patients' subjective illness theories related to their chronic disease. Since these encounters have a relatively informal character [3], patients' subjective illness theories receive greater importance than in interactions concerning acute medical care.

Comparing everyday conversations with institutional encounters Heritage [1] identified differences in turn taking, overall structural organisation, sequence organisation, turn design and lexical choice. He also mentions several previous studies on communication disturbances due to the asymmetry in doctor-patient relationship [1]. Investigating the concept of dominance, asymmetry and power Alexander Brock and Dorothee Meer [4] point out that institutional hierarchy and the possible power relations leading to inequality are multifaceted, heterogeneous phenomena. Their description within the interaction is possible through reconstructive analysis, which studies the existence of asymmetries in the empiria. The prerequisite for the analysis of the asymmetries is identifying certain points of reference for the observation [4]. Asymmetry, in turn, can be defined as communicative inequality concerning the criteria or phenomena identified by the researcher.

Material and method

In the present case-study the interactional identification of communicative inequality was carried out relying on two points of reference: turn design and turn taking. Turns were analysed quantitatively focusing on the number of turns and their length in time.

When investigating into the system of turn taking, a multidimensional approach was used: 1/ the order of turn taking (other selection/self selection) 2/ taking, keeping and defending the right for speech (successful/unsuccessful) 3/ relationship to the content of the previous turn and 4/ interactive devices used for taking the turn. In fact, points 3 and 4 are necessary for providing a proper descrip-

Table I. Turns with and without recipient signals

	Turns with recipient signals	Recipient signals			Turns without recipient signals
		Oh (óha)	Hm (ühüm)	Hm (aha)	
doctor	54	1	2	2	*49*
patient	51		1		*50*
doctor's assistant	5		1		*4*

tion of categories successful / unsuccessful in point 2 and thus they are not independent variables. The talk analysed in the present study took place between a family physician and his 71 year-old female patient. The patient was diagnosed with hypertension more than ten years before the time of the study. She regularly presented to her family doctor to receive hypertension care. Every three months she was supposed to see her doctor for the new prescriptions. The purpose of the encounter was to discuss the blood pressure values and also the modification of medication. The encounter lasted for nearly six minutes.

Results

In Table I data in italics indicate the number of turns where no recipient's signal manifested. Considering the number of the doctor's and the patient's turns – with or without recipient's signal no significant differences could be found. An even lesser difference could be found in the doctor's and patient's speech time, while the time of simultaneous speech was relatively long (Table II).

Interactive types of turn taking are shown in Table III. While variety 1 was characteristic sheerly of the patient, tools 3 and 4 were used by the physician exclusively.

The most frequently applied tool for taking the turn used by both parties was interrupting the partner's speech. The patient a lot more frequently interrupted the physician's talk (Table IV). The study of the outcome of simultaneous talk, i.e. what happened to the right for speech, is shown in Table V.

The physician was three times more successful in regaining the right for speech temporarily lost in simultaneous speech.

Table VI contains a transcribed segment of the original Hungarian doctor-patient encounter. Table VII is the English version of the transcription in Table VI.

Table III. Interactive types of turn taking

1	Without interrupting	**Pauses** **Contentual end** of the other speaker's utterance
2	Interrupting the partner's speech	**Simultaneous speech**
3	Initiation of a speech act	**Question** "Did you tell me what you asked me, so that we prescribed all of them" **Imperative** "Then take it little earlier, something like about six o' clock"
4	Opening signals	"Now let's see…"

Table II. Time allocation among partners of conversation

Total time (min)	Doctor (min)	Patient (min)	Doctor's assistant (min)	Simultaneous speech (min)
5.96	1.99	1.98	0.11	1.25

Discussions

The present case study was undertaken to find an answer to the question how the interactive structure of doctor-patient encounters determines the interactive elaboration of patients' lay illness theories and how subjective lay illness theories in the interaction influence the structure of the encounter. Since it is a type of institutional encounters, on answering the question, dominance and communicative asymmetry manifesting in the interaction could not be neglected. Turn design and turn taking within the encounter were analysed. Sheerly quantitative investigation into the participatory mechanisms in conversations does not facilitate the understanding of asymmetry and doctor's dominance [5] within the structure of the interaction. Qualitative investigation focusing on turn taking confirmed data found in Heritage [1]: other selection was the most frequent patient's choice in reply to the doctor's question. Self-selection was used by the patient to utilize the technical break while the physician was thinking or signing the prescriptions. This observation is congruent with the findings of previous studies [1] investigating into the interactional appearance of physicians' dominance [5]. A special use of the temporary silence in communication could be observed when the patient, while the sphygmomanometer was being installed, started to talk about her present complaints again. This way of self-selection was characteristic of all but one conversation in the corpus. Investigating into the interactive language tools [6] of taking the speaker's turn is also important. The present study reveals that both parties were using the tool interrupting the partner, which, as a rule, resulted in simultaneous speech [6].

If regaining the right for speech [4] is investigated from another aspect, i.e. whether or not any response to the content of the partner's previous turn can be observed, some interesting elements in the dynamics of turn taking can be revealed.

"…doctor: then take it a little earlier, something like about six o' clock or … patient interrupting: I would take it about five, half past four", "doctor: for they generally reach the maximum effect some one or two hours later and if it does not go into the night then you can still… patient

Table IV. Interrupting the partner's speech

Patient	Doctor
8	2

Table V. Simultaneous speech and regaining right for speech

Regaining right for speech	Regaining right for speech
Patient	Doctor
2	6

Table VI. Hungarian transcript of a segment in the doctor-patient encounter

118	**B**	**=<<all>mer úgy vagyok vele hogy napközben beveszem**
119		de mondom este ha olyan rosszul leszek akkor kinek szóljak> ((nevet))
120	**O**	**((nevet)) hát kicsit korábban vegye be akkor (.) mit tudom olyan hat óra felé vagy↑**
121	**B**	=((mosolyog)) öt óra felé szoktam [fél öt ötkor
122	**O**	aha
123	**B**	a cukorgyógyszerrel ( )
124	**O**	mer az kiderül] egy két óra múlva (-)
125		mer a maximális hatást azért általában néhány egy két óra múlva érik el
126		.h és akkor hogyha ez nem éjszakába nyúlik akkor tud azért (-)
127	**B**	=meg úgy ég az arcom mindenem
128		akkor meg úgy érzem hogy tiszta öö itt a nyaka egy
129	**O**	[érdekes
130	**B**	minthogyha egy] lángba vónák (-)
131	**O**	nem szokott ilyet csinálni de hát lehetséges mindegy
132		=hát nem tudom ha <<all>egyet egy felet bír akkor én azért mégis rábeszélném a kétszer
133		félre mer .h ez a nagyon magas vérnyomás>
134		bár most ön (.) csodálatos módon bírja ezt már évek óta
135		de (.)azért ez sok veszéLLYEL↓ fenyeget↓ (-)
136		úgyhogy erre vigyázni kéne hogy ne menjen ennyire föl a vérnyomás <<all>tehát ez fontos lenne>↓
137	**B**	=de semmi olyan há nem DOhányzok nem Iszok abszolút
138	**O**	[hát most hogy ez mitől van
139	**B**	semmit a vizen kívül
140	**O**	megint más kérdés(-)
141	**B**	mit tudom én hogy]
142	**O**	de de fontos hogy lenmarad [lentartsuk
143	**B**	<<p>ühüm>] (-)
144	**O**	na jól van ↓
145	**B**	=mer tényleg az ennivalóval is nagyon vigyázok
146		mer a három zsemlét szigorúan
147	**O**	=most (.) ö a elmondta hogy mit öö mit kér
148		=tehát csak azért hogy az összeset írtuk most?

Table VII. English transcript of a segment in the doctor-patient encounter

118	**P**	**=<<all> cause I would take it during the day**
119		> but I say if I feel so bad in the evening who should I call((laughs))
120	**D**	**((laughs)) then take it little earlier (.) something like about six o' clock↑**
121	**P**	=((smiles)) I would take it about five [half past four
122	**D**	aha
123	**P**	( )with the diabetes pills
124	**D**	(-) cause it turns out in one or two hours
125		for they generally reach the maximum effect some one or two hours later
126		.h and if it does not go into the night then you can still(-)
127	**P**	=and my cheek and everything burns so much
128		then and I feel as if her my neck
129	**D**	[interesting
130	**P**	as if I were in a] big flame (-)
131	**D**	it usually doesn't do anything like that but maybe
132		=never mind I don't know if <<all>you could do with a half than I would still talk you into
133		two halves.h because this very high blood pressure >
134		(.) though you (.) marvelously stand this for years
135		(.) but (.) this is quite dangerous ↓ (-)
136		<<all so you should take care not to have so high blood pressure, so this would be important >>↓
137	**P**	=but I don't do anything like, I don't smoke or drink at all
138	**D**	[now what causes it
139	**P**	nothing just water
140	**D**	it's another question(-)
141	**P**	I have no idea that]
142	**D**	[but it's important that it stays low, we should lower it
143	**P**	<<p> hm >] (-)
144	**D**	all right then ↓
145	**P**	=cause I really take care of what I eat
146		the three bread rolls strictly
147	**D**	=now (.) er did you tell me what you asked for
148		=so that we prescribed all of them

interrupting: and my cheek and everything burns so much then and I feel as if er... my neck as if I were in a big flame… doctor interrupting: it usually doesn't do anything like that but maybe, never mind I don't know if you could do with a half than I would still talk you into two halves…"

Doctor and his patient take turns in interrupting each other's utterances. The interruptions at the level of interaction served as tools of fighting for local and transitional dominance. The communicative dominance of the actual speaker further increased by the fact that utterances realised this way content-wise were not related to the partner's previous (interrupted) utterance. The re-gained right for speech was used to fully present the doctor's professional arguments and recommendations (Lines 125, 131 and 142-144) and also to restore his dominant role in the interaction. When the patient dared to interrupt the doctor's utterance, in most of the cases she did it by relating her subjective experiences, which sometimes partially did but in most of the cases did not count as any response whatsoever to the doctor's previous utterance (Lines 118-119, 127-128, 130, 137, 139, 145-146).

Table V. Signs used at transcription

(.)	micro pause
.hh .hyes	a dot prior to a sound or word marks hearable in-breath
(-),(--),(---)	a short, medium or longer pause btw 0.25-0.75 sec and 1 sec lengthening
[ ]	simultaneous speech (speaking together)
( )	it cannot be heard what is being said
akZENT	primer or main emphasis
=	new turn or a direct, quick connection of a unit
<<all> >	allegro, especially quick pace
↑	pointed arrow upwards indicates a marked rising intonational shift
↓	pointed arrow downwards indicates a marked falling intonational shift
((laughs))	comments on what happens or how something is done or said
<<p> >	piano, especially quiet place

In simultaneous speech subjective illness theories were running parallel to the doctor's rational and professional argumentation [7]. Of this parallel speech it was always the professional argumentation that became the winner, which eventually did not react [8] to the content of the patient's utterance. Considering the interaction as a whole, this may be explained at least in two ways. On the one hand, the representative of the institution constantly signalises (not at the conscious level) his communicative superiority, influencing and, at the same time, restricting the degree of interactive elaboration of the subjective illness theories. On the other hand, if subjective illness theories topicalised by

the patient are regularly followed by the doctor's responses not related to their content, their eligibility in the interaction gets questioned. The patient thus receives permanent feedback (not at the conscious level) that what she says has no importance for the doctor. This involves the risk that the patient will not formulate her illness theories in later doctor-patient dialogues or will do so only roughly.

No effective therapeutic cooperation is possible without awareness of the patient's subjective illness theories [9], since "they guide patients' preferences for treatment and the behaviours in which they engage over time." [10].

Conclusions

Further research is needed to generalise the conclusions of the present case study. A possible first step of this could be the investigation of the whole corpus, which could add further data to the research of the success or failure of doctor-patient communication. The focal points and procedures used in the present study can be applied in further studies with the hope of success.

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